

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be signed by the hospital attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

118949

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Caroline		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Denton		12 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
511 Franklin St.		511 Franklin St.	
3. NAME OF DECEASED (Type or print)		First	Middle
		William	Edwin
		Collins	Collins
4. DATE OF DEATH		Month	Day
		August	20
		19	61
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Male		White	April 3, 1883
8. AGE (In years last birthday)		9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS. Hours
78 yrs.		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Farmer		Agriculture	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William Henry Collins		Hester Ann Story	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
no none		214 34 9135 Mrs. Ruth Collins, Denton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
6100		Cardio-Vascular Disease Renal 2 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Hyper-trophied prostate 4 yrs	
DUE TO		DUE TO	
DUE TO			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 19</u> 1960 to <u>Aug. 19</u> 1961, that (I) (we) last saw the deceased alive on <u>Aug. 19</u> 1961, and that death occurred at <u>Denton</u> from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <u>Aqusey J. George</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Dawson O. George		22d. ADDRESS Denton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/22/61	
23c. NAME OF CEMETERY OR CREMATORIAL GROVE Cemetery		23d. LOCATION (City, town, or county) (State) Caroline County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Hollis</u> ADDRESS <u>Preston, Md.</u>		25a. REC'D BY REGISTRAR DATE AUG 23 '61	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8958

CERTIFICATE OF DEATH

10046

1. PLACE OF DEATH a. COUNTY <i>Caroline</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hillsboro</i>		c. LENGTH OF STAY IN 1b <i>30 YR.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>CYRENE LEE Hammond</i>		First	Middle
4. DATE OF DEATH <i>8 31 1961</i>		Last	Month Day Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>82 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm owner</i>	11. BIRTHPLACE (State or foreign country) <i>TENNESSEE</i>
13. FATHER'S NAME <i>W.H. Hammond</i>		14. MOTHER'S MAIDEN NAME <i>Polly Sellis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>		16. SOCIAL SECURITY NO. <i>131-12-2797</i>	17. INFORMANT <i></i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH <i>6 hr</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		Coronary Insufficiency	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i>		DUE TO Arterio Sclerosis (c) <i></i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		Probably 6 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>Aug 30 1961, a.m. Aug 31 1961</i>
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 30 1961</u> to <u>Aug 31 1961</u> , that (I) (we) last saw the deceased alive on <u>12:30 A 1961</u> , and that death occurred at <u>12:30</u> from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <i>E. Paul Knotts</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <i>E. Paul Knotts M.D.</i>		22d. ADDRESS <i>Denton, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9-3-61</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Sandtown Cem</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>James D. White</i>		ADDRESS <i>Eaton, Md.</i>	23d. LOCATION (City, town, or county) (State) <i>Hillsboro Md</i>
25a. REC'D BY REGISTRAR DATE <i>SEP 11 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

8959

## **CERTIFICATE OF DEATH**

448950

1. PLACE OF DEATH a. COUNTY <b>Caroline</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>		b. COUNTY <b>Caroline</b>	
c. LENGTH OF STAY IN lb <b>8 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>None</b>			
3. NAME OF DECEASED (Type or print) <b>Mamie</b>		4. DATE OF DEATH Last Month Day Year <b>None 8 9 1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9. AGE (In years last birthday) <b>65 yrs.</b>	
10. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Gunnings</b>	
14. MOTHER'S MAIDEN NAME <b>None</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Rev. Amous Jenkins Greensboro, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>420.1</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>Coronary Thrombosis</b>	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO <b>Hypertensive Cardiovascular Disease</b>		(c)	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) <b>Spastic Hemiplegia</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED Whila at work <input type="checkbox"/> Not Whila at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 10 1961</b> to <b>Aug. 9 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug. 9 1961</b> , and that death occurred at <b>11:45 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles H. Stonesifer</b>		22b. DATE SIGNED <b>Aug. 14 '61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>		22d. ADDRESS <b>Greensboro, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-12-61</b>	
23c. NAME OF CEMETERY OR CREMATORIUM <b>Cokers</b>		23d. LOCATION (City, town or county) (State) <b>Greensboro, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulaire &amp; Greensboro, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 14 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>			

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VR A15 (4)  
15M 9/60

66

Enclosed

envelope

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box 8

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8

box

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80 82-4-21

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8960

## CERTIFICATE OF DEATH

Reg. Dist. No. 08951

1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DENTON</b>		c. LENGTH OF STAY IN 1b <b>life</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <b>DENTON</b>				
3. NAME OF DECEASED (Type or print) <b>ELIZABETH</b>		First <b>ELIZABETH</b>	Middle <b>LANE</b>			
4. DATE OF DEATH Month <b>AUG</b>		Day <b>15</b>	Year <b>1961</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR 2, 1890</b>			
9. AGE (In years lost birthday) <b>71 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>WILLIAM SLOAN</b>				
14. MOTHER'S MAIDEN NAME <b>SALLIE GRIFFITH</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				
16. SOCIAL SECURITY NO. <b>442-12-0000</b>		17. INFORMANT <b>Mrs Mary Saylor, Denton, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Vascular Renal Disease</b> DUE TO <b>442X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
19. INTERVAL BETWEEN ONSET AND DEATH <b>12 months</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>Aug 18, 1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Denton</b>	20f. (City or town) <b>Denton</b>	(County) <b>Caroline</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>Aug 14</b> , 1961, to <b>Aug 15</b> , 1961, that I last saw the deceased alive on <b>Aug 15</b> , 1961, and that death occurred at <b>10:45 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Dawson D. George</b> M.D. ADDRESS (Street, city or town, state) <b>Denton, Md.</b> DATE SIGNED						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Aug 18, 1961</b>		22b. DATE THEREOF <b>Aug 18, 1961</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Denton</b>	22d. LOCATION (City, town, or county) <b>Denton</b> (State) <b>Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Virgil Mooreson Denton</b>		ADDRESS <b>Denton</b>	24a. REC'D BY REGISTRAR <b>AUG 21 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Thomas</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

108952

8961

1. PLACE OF DEATH  
a. COUNTY

Caroline

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Federalburg

c. LENGTH OF STAY IN 1b  
RURAL and give nearest town)

Life

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

Walkertown

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Maryland

b. COUNTY Caroline

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Federalburg

## d. STREET ADDRESS

Walkertown

e. IS RESIDENCE  
ON A FARM?YES  NO 1. NAME OF  
DECEASED  
(Type or print)First  
MargaretMiddle  
CookLast  
Liden4. DATE  
OF  
DEATHMonth  
AugustDay  
26  
Year  
19615. SEX  
Female6. COLOR OR RACE  
White7. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED 8. DATE OF BIRTH  
September 14, 19039. AGE (In years  
last birthday)  
57 yrs.10. IF UNDER 1 YEAR  
Months Days Hours Min.  
11. BIRTHPLACE (State or foreign country)  
Caroline Co., Maryland12. CITIZEN OF WHAT COUNTRY?  
U.S.A.13. FATHER'S NAME  
Edward Cook14. MOTHER'S MAIDEN NAME  
Jane Armstrong15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

No

(If yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

None

## 17. INFORMANT

W. Elbert Liden, Jr., Federalsburg, Maryland

Address

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Abdominal carcinomatosis

INTERVAL BETWEEN  
ONSET AND DEATH

10 months

1590X  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

(b)

DUE TO

(c)

DUE TO

(d)

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Hour a. m. 19  
p. m.20d. INJURY OCCURRED  
While at work  Not while  
at work 20e. PLACE OF INJURY (Name, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 1-27 1961, to 8-24 1961, that (I) (we) last  
saw the deceased alive on 8-24 1961, and that death occurred at 12:20 AM, from the causes and on the date stated above.

## 22a. SIGNATURE

Robert W. Trever

M.D. ATTENDING  
PHYS. MED.  
DIRECTOR  STAFF  
PHYS. 22b. DATE  
SIGNED22c. PHYSICIAN'S  
NAME (Type)

ROBERT W. TREVER, M.D.

## 22d. ADDRESS

202 Dover Street

Federalsburg, Maryland

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

## 23b. DATE THEREOF

Aug. 29, 1961

## 23c. NAME OF CEMETERY OR CREMATORI

Bloomyery Cemetery

## 23d. LOCATION (City, town, or county)

(State)

Near Federalsburg, Maryland

## 24. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

J.J. Frampton and Son, Federalsburg, Maryland

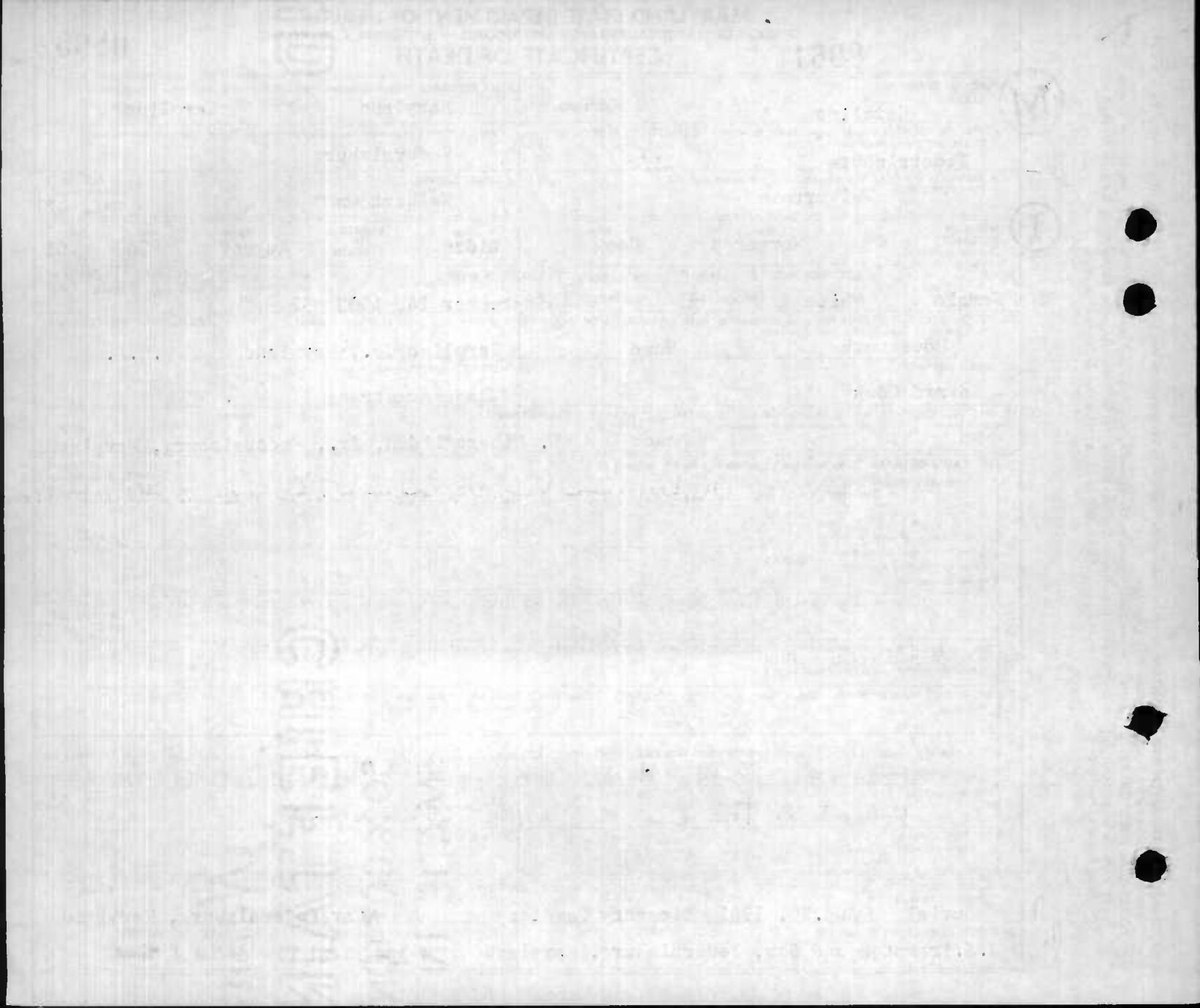
## 25a. REC'D BY REGISTRAR

DATE AUG 31 '61

## 25b. REGISTRAR'S SIGNATURE

C. Arthur S. Krause

B



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8962 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08953

TO DEPUTIZY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

M

X

I

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Maryland		c. LENGTH OF STAY IN 1b 12 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Maryland	
3. NAME OF DECEASED (Type or print) First Charles Middle Jerome Last Mack		4. DATE OF DEATH 8 Month 11 Day Year 19 61	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8-14-1879	
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Field Engineer		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Oklahoma	
13. FATHER'S NAME No Record		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 17. INFORMANT 153-03-3855 Charles Shoemaker Address 329 Jackson Stree Manville, N.J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
<p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gun shot wound to RT Temple</i> DUE TO <i>976X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Shock, External Hemorrhage</i> DUE TO (c) <i>Self Inflicted</i></p>			
INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p. m. 8-11 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) His House	
20f. (City or town) Rural Maryland (Carroll Md)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Dawson O. George</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dawson O. George		DATE SIGNED 8-11-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-13-61	
22c. NAME OF CEMETERY OR CREMATORIAL Greensboro		22d. LOCATION (City, town, or county) (State) Greensboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Boulair Greensboro, Md.</i>		ADDRESS	
		24a. REC'D BY REGISTRAR DATE AUG 15 '61	
		24b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8963

## CERTIFICATE OF DEATH

Reg. Dist. No. 118954

1. PLACE OF DEATH a. COUNTY <i>CHARLOTTE</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>CHARLOTTE</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>DENTON</i>		c. LENGTH OF STAY IN 1b <i>RURAL and give nearest town</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>DENTON</i>		d. STREET ADDRESS <i></i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>CHARLIE</i>	Middle <i></i>	Last <i>McNATT</i>	4. DATE OF DEATH <i>AUG 20 1961</i>	Month <i>AUG</i>	Day <i>20</i>	Year <i>1961</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>SEPT 7, 1899</i>	9. AGE (In years last birthday) yrs. <i>61</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TAXI DRIVER</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>OWNER</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
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13. FATHER'S NAME <i>JOHN McNATT</i>	14. MOTHER'S MAIDEN NAME <i>GEORGIA CLIMBRE</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>	16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>MRS ELLIS MURPHY GREENSBORO</i>	Address <i></i>

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i>		<i>1 hour</i>
DUE TO Conditions, if any, which goe rise to immediate cause (a), stating the under- lying cause last. <i></i>		
(b) <i>Left-sided heart failure</i>		<i>1" or more</i>
DUE TO <i></i>		<i>SEVERAL</i>
(c) <i>Hypertensive cardiovascular Disease</i>		<i>Years</i>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Obesity</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>		

21. I certify that I attended the deceased from <i>24 - Feb. 1961</i> to <i>Present</i> , that I last saw the deceased alive on <i>8 - August 1961</i> , and that death occurred at <i>134</i> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>16 N 2nd St., Denton, Md 21629</i>	DATE SIGNED <i>August 22, 1961</i>
ACTUAL SIGNATURE <i>Dale R. Kellman</i>	M.D.		
PHYSICIAN'S NAME (Type) <i>Dale R. Kellman, M.D.</i>	16 N. Second St. Denton, Maryland	August 22, 1961	

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>AUG 23, 1961</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>GREENSBORO</i>	22d. LOCATION (City, town, or county) <i>GREENSBORO MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. Woods Denton</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR <i></i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kellman</i>
DATE <i></i>		DATE <i>AUG 24 '61</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8964

## CERTIFICATE OF DEATH

08955

1. PLACE OF DEATH a. COUNTY <b>Caroline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston - Rural</b>		c. LENGTH OF STAY IN 1b <b>30 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Near Friendship</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston - Rural</b>	
3. NAME OF DECEASED (Type or print) <b>Hilda</b>		4. DATE OF DEATH <b>Williamson</b>	
First <b>Hilda</b>	Middle <b>Meeds</b>	Last <b>Williamson</b>	Month <b>August</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 25, 1897</b>
9. AGE (In years last birthday) <b>64</b>		10. IF UNDER 1 YEAR Months <b>64</b>	11. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Caroline Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Cyrus Meeds</b>		14. MOTHER'S MAIDEN NAME <b>Ida Jewell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Melvin W. Williamson, Preston, Md., R.F.D.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)</b> <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.</i> <b>DUE TO</b> <b>(b)</b> <b>DUE TO</b> <b>(c)</b> <i>Car Pulmonary (Chronic)</i> <i>Pulmonary Cysts</i> <i>Pulmonary Emphysema</i> <b>Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)</b>			
19. INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 24 1961</b> to <b>Aug 25, 1961</b> that (I) (we) last saw the deceased alive on <b>Aug 25, 1961</b> and that death occurred at <b>M</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>Dr. H. B. Plummer</i>		22b. DATE SIGNED <b>8/28/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. H. B. PLUMMER</b>		22d. ADDRESS <b>Preston Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 27, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Junior Order Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Near Preston, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son, Federalsburg, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 31 '61</b>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

